	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED		
155704			B. WING		06/14/2012	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
NAVAL DDA		DELLAR OFNITER		MAIN ST		
WALDRON HEALTH AND REHAB CENTER			WALDI	RON, IN 46182		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	` `	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG F0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFECENCE!)	DATE	
1 0000						
	This visit was fo	or the Investigation of	F0000	This Plan of Correction is the		
	Complaint IN00	_		facility's credible allegation of		
	Complaint 11 voc	7100373.		compliance.		
	Complaint IN00	0108595 - Substantiated.		Preparation and/or execution of thi	s	
	•	ficiencies related to the		plan of correction does not		
	allegations are o			constitute admission or agreement by the provider to the facts alleged		
		ut 1 525.		or conclusions set forth in the		
	Survey date: 06	5/14/12		statement of deficiencies. The plan		
	Survey dute. 60	7/17/12		of correction is prepared and/or		
	Facility number	. 000423		executed solely because it is		
	Provider number			required by the provisions of federa	ıl	
	AIM number: 1			and state law.		
	7 Mivi number.	100270430				
	Team:					
	Joyce Hofmann	RN TC				
	Barbara Hughes					
	Buroura Tragnes	,,				
	Census bed type	7.				
	SNF/NF: 61					
	Total: 61					
	1000.01					
	Census payor ty	me:				
	Medicare: 12	pe.				
	Medicaid: 38					
	Other: 11					
	Total: 61					
	1000.01					
	Sample: 3					
	This deficiency	also reflects state findings				
		nce with 410 IAC 16.2.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
155704		A. BUILDING	00	06/14/2012	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	307 1 1120 12
NAME OF P	PROVIDER OR SUPPLIEF			MAIN ST	
	ON HEALTH AND R		WALDF	RON, IN 46182	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
		5/20/12 by Suzanne			
	Williams, RN	•			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 11FN11

Facility ID: 000423

If continuation sheet Page 2 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		00		X3) DATE SURVEY COMPLETED			
155704		A. BUILDING			06/14/	14/2012	
NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER			p. v. z.v	STREET A	ADDRESS, CITY, STATE, ZIP CODE MAIN ST RON, IN 46182		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
F0323 SS=G	483.25(h) FREE OF ACCID HAZARDS/SUPI The facility must environment rem hazards as is po receives adequa assistance devic Based on record interviews, the fa supervision was transfer of a resid lift, resulting in t the lift and sustal and a head injury reviewed for acc [Resident #B]  Findings include  During an interv 6/14/12 at 1:15 p indicated that in moved with a me at 8:30 p.m., from her bed, she fell floor beside her b fractured femur, injury. She indicaccident occurred CNA moving her usually two peop was helping her in	DENT ERVISION/DEVICES ensure that the resident lains as free of accident ssible; and each resident te supervision and es to prevent accidents. view, observation, and lacility failed to ensure provided during the dent with a mechanical the resident falling from laining multiple fractures or, for 1 of 3 residents idents in a sample of 3.  Herew with Resident #B on firm., Resident #B the process of being echanical lift on 4/12/12 on her motor scooter to lout of the sling onto the loed resulting in a broken ribs and a head lated that when the did, there was only one one. She indicated there are lele, but the other CNA	F03		F 323 What corrective action(s will be accomplished for those residents found to have been affected by the deficient practice. Resident # B continues to be transferred using the mechanicity without difficulty. Immediate re-education began with staff proper technique for use of mechanical lifts with return demonstration. Resident treate at the hospital and returned to facility. Attachment # 1 How of residents having the potential be affected by the same defici practice will be identified and what corrective action(s) will be taken; All staff involved in use mechanical lifts with return demonstration. New admission are reviewed by therapy to determine appropriate use of mechanical lifts for transfers. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not reconversing staff were re-educate on proper technique for use of mechanical lifts on 4/13/2012 or return demonstration by all CN and nurses, and were	ce; cal e on ed the ther to ent e of ed es cur; ed with	06/28/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 11FN11

Facility ID: 000423

If continuation sheet

Page 3 of 7

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER: 155704  INVINO  INVINO  INVINO  NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER  WALDRON, IN 46182  INVINO  INVINORATE STREET ADDRESS, CITY, STATE, ZIP CODE  505 N MAIN ST  WALDRON, IN 46182  WALDRON, IN 46182  INVINORATION, IN 46182	STATEMEN			(X2) N	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER  WALDRON, IN 46182  (XS) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION)  Treviewed on 6/14/12 at 2:20 p.m. and indicated the resident had diagnoses which included, but were not limited to, multiple selcrosis, scizure disorder, and depressive disorder. Resident #B's quarterly Minimum Data Set [MDS] assessment dated 03/06/12 and significant change MDS dated 04/25/12, indicated the resident had a BIMS score of "15" which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  The MDS and ADDES AND	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 00			COMPLETED			
NAME OF PROVIDER OR SUPPLIER  WALDRON HEALTH AND REHAB CENTER  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  reviewed on 6/14/12 at 2:20 p.m. and indicated the resident had a BIMS score of "15" which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and of fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  SUMMARY STATEMENT OF SOR WALDRON, IN 46182  WALDRON, IN 46182  WALDRON, IN 46182  ID PREFIX TAG WALDRON, IN 46182  ID PREFIX CACHESPARA OF COBBECTION (AS) WALDRON, IN 46182  ID PREFIX TAG WALDRON	155704						06/14/2	2012	
WALDRON HEALTH AND REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR ISE (IDENTIFYING INFORMATION)  reviewed on 6/14/12 at 2:20 p.m. and indicated the resident had diagnoses which included, but were not limited to, multiple sclerosis, seizure disorder, and depressive disorder. Resident #B's quarterly Minimum Data Set [MDS] assessment dated 03:06/12 and significant change MDS dated 04/25/12, indicated the resident had a BIMS score of "115" which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  The Matter of Deficiencies and a fell in the process. Nursing administration or designee will monitor 1 mechanical lift transfer daily X 1 month, then 3 days per week X 1 month, then 3 days per week X 1 month, then 3 days per week X 1 month, then 3 devicated on proper technique with return demonstration before they use the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly, Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months; ""Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determining recommended lift	2712	NO. 1 TO 1	L			ADDRESS, CITY, STATE, ZIP CODE			
WALDRON, IN 46182  ### WALDRON HEALTH AND CHORL SANCH	NAME OF PROVIDER OR SUPPLIER								
reviewed on 6/14/12 at 2:20 p.m. and indicated the resident had diagnoses which included, but were not limited to, multiple sclerosis, seizure disorder, and depressive disorder. Resident #B's quarterly Minimum Data Set [MDS] assessment dated 03/06/12 and significant change MDS dated 04/25/12, indicated the resident had a BIMS score of "15" which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  reviewed on 6/14/12 at 2:20 p.m. and on the indicated the resident mide and a fall and required a notation  reviewed on 6/14/12 at 2:20 p.m. and on the indicated the resident process. Nursing administration or designee will monitor 1 mechanical lift transfer daily X1 month, then 3 days per week X 1 month. Each new staff member will be educated on proper technique with return demonstration before they use the mechanical lifts. Attachment # 2 How the corective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the CA&A committee on a monthly basis X 6 months.**Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift		-			WALDF				
reviewed on 6/14/12 at 2:20 p.m. and indicated the resident had diagnoses which included, but were not limited to, multiple sclerosis, seizure disorder, and depressive disorder. Resident #B's quarterly Minimum Data Set [MDS] assessment dated 03/06/12 and significant change MDS dated 04/25/12, indicated the resident had a BIMS score of "15" which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  reviewed on 6/14/12 at 2:20 p.m. and indicated to proper that 2 staff are present during the lift process. Nursing administration or designee will monitor 1 mechanical lift transfer daily X 1 month, then 3 days per week X 1 month. Each new staff member will be educated on proper technique with return demonstration before they use the mechanical lifts. Attachment # 2 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months.**">Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift						PROVIDER'S PLAN OF CORRECTION		` '	
reviewed on 6/14/12 at 2:20 p.m. and indicated the resident had diagnoses which included, but were not limited to, multiple sclerosis, seizure disorder, and depressive disorder. Resident #B's quarterly Minimum Data Set [MDS] assessment dated 03/06/12 and significant change MDS dated 04/25/12, indicated the resident had a BIMS score of "15" which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  re-educated of the facility's specific preference that 2 staff are present during the lift process. Nursing administration or designee will monitor 1 mechanical lift transfer daily X 1 month. Hen 3 days per week X 1 month. Each new staff member will be educated on proper technique with return demonstration before they use the mechanical lifts. Attachment # 2 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months.***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift		` `				CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
indicated the resident had diagnoses which included, but were not limited to, multiple sclerosis, seizure disorder, and depressive disorder. Resident #B's quarterly Minimum Data Set [MDS] assessment dated 03/06/12 and significant change MDS dated 04/25/12, indicated the resident had a BIMS score of "15" which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  specific preference that 2 staff are present during the lift process. Nursing administration or designee will monitor 1 mechanical lift transfer daily x 1 month, then 3 days per week x 1 month. Each new staff member will be educated on proper technique with return demonstration before they use the mechanical lifts. Attachment # 2 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months. ***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift	TAG				TAG	,		DATE	
which included, but were not limited to, multiple sclerosis, seizure disorder, and depressive disorder. Resident #B's quarterly Minimum Data Set [MDS] assessment dated 03/06/12 and significant change MDS dated 04/25/12, indicated the resident had a BIMS score of "15" which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  are present during the lift process. Nursing administration or designee will monitor 1 mechanical lift transfer daily X 1 month, then 3 days per week X 1 month. Each new staff member will be educated on proper technique with return demonstration before they use the mechanical lift transfer daily X 1 month, then 3 days per week X 1 month. Each new staff member will be educated on proper technique with return demonstration before they use the mechanical lift. Attachment will be educated on proper technique with return demonstration before they use the mechanical lift. Attachment will be educated on proper technique with return demonstration before they use the mechanical lift. Attachment will be educated on proper technique with return demonstration before they use the mechanical lift. Attachment will be educated on proper technique with return demonstration before technique with return demonstration before they use the mechanical lift. Attachment will be educated on proper technique with return demonstration before they use the mechanical lift. Attachment will be educat		reviewed on 6/14	1/12 at 2:20 p.m. and				_		
which included, but were not limited to, multiple sclerosis, seizure disorder, and depressive disorder. Resident #B's quarterly Minimum Data Set [MDS] assessment dated 03/06/12 and significant change MDS dated 04/25/12, indicated the resident had a BIMS score of "15" which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  which indicated will onlice 1 mechanical lift transfer daily X 1 month, then 3 days per week X 1 month. Each new staff member will be educated on proper technique with return demonstration before they use the mechanical lifts. Attachment # 2 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months.***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift		indicated the resident had diagnoses							
multiple sclerosis, seizure disorder, and depressive disorder. Resident #B's quarterly Minimum Data Set [MDS] assessment dated 03/06/12 and significant change MDS dated 04/25/12, indicated the resident had a BIMS score of "15" which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation		which included.	but were not limited to.						
depressive disorder. Resident #B's quarterly Minimum Data Set [MDS] assessment dated 03/06/12 and significant change MDS dated 04/25/12, indicated the resident had a BIMS score of "15" which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  mechanical lift transfer daily X 1 month, then 3 days per week X 1 month. Each new Staff member will be educated on proper technique with return demonstration before they use the mechanical lifts. Attachment # 2 How the corrective action(s) will be monitored to ensure the							ווכ		
quarterly Minimum Data Set [MDS] assessment dated 03/06/12 and significant change MDS dated 04/25/12, indicated the resident had a BIMS score of "15" which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  month, then 3 days per week X 1 month. Each new staff member will be educated on proper technique with return demonstration before they use the mechanical lifts. Attachment # 2 How the corrective action(s) will be monthored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months. ***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift		_				_	.		
assessment dated 03/06/12 and significant change MDS dated 04/25/12, indicated the resident had a BIMS score of "15" demonstration before they use the mechanical lifts. Attachment # 2 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the Qa&A committee on a months.***Additional request received 07/06/2012: F0323: sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  month. Each new staff member will be educated on proper technique with return demonstration before they use the mechanical lifts. Attachment # 2 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before they use the mechanical lifts. Attachment # 2 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the Qa&A committee on a monthly basis X 6 months: ***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift		_							
assessment dated 03/06/12 and significant change MDS dated 04/25/12, indicated the resident had a BIMS score of "15" which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  will be educated on proper technique with return demonstration before they use the mechanical lifts. Attachment # 2 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months.***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift		1 ^		1					
change MDS dated 04/25/12, indicated the resident had a BIMS score of "15" demonstration before they use the mechanical lifts. Attachment # 2 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months.***Additional request received 07/06/2012: F0323: sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation to the determining recommended lift.			•						
which indicated she was independent with cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  the mechanical lifts. Attachment # 2 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months.***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift		_				•			
cognitive skills for daily decision making.  The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  2 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months.**-Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift		the resident had	a BIMS score of "15"						
cognitive skills for daily decision making.  The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  2 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months.***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift		cognitive skills for daily decision making. The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since							
The MDS's also indicated the resident needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  The MDS's also indicated the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months: ***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift						` '	will		
needed extensive assist of two persons for transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  i.e., what quality assurance program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months.***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift							_		
transfers.  Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  program will be put into place; DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months.***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift						•	,		
Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  DON or designee will check the audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months.***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift									
Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  audits weekly. Any and all concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months.***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift									
Review of Occupational Therapy notes dated 02/16/12 at 2:50 p.m. and 04/17/12 at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  concerns will be addressed individually, and brought before the QA&A committee on a monthly basis X 6 months.***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift						_			
at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  the QA&A committee on a monthly basis X 6 months.***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift									
at 7:04 a.m., indicated Resident #B had used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  the QA&A committee on a monthly basis X 6 months.***Additional request received 07/06/2012: F0323: Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift						individually, and brought befor	re		
used a walker, then had a decline and a fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  monthly basis X 6 months.***Additional request received 07/06/2012: F0323:  Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift									
fall, and required a Hoyer lift since sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  Reduitional request received 07/06/2012: F0323:  Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift									
sustaining an ankle injury in October of 2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  Describe the system in which you will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift						•			
2011.  Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  will communicate the resident(s) appropriate transfer care, determined by therapy, to your direct care staff. After determining recommended lift				1					
appropriate transfer care, determined by therapy, to your direct care staff. After  (ADL) Care Plan indicated a notation determining recommended lift			1						
Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  determined by therapy, to your direct care staff. After determining recommended lift						(3)			
Resident #B's Activities of Daily Living (ADL) Care Plan indicated a notation  direct care staff. After determining recommended lift		, ,					<sub>r</sub>		
(ADL) Care Plan indicated a notation determining recommended lift							•		
		` ′				_			
Hover lift for all transfers. The resident's to nursing via form (see attached				1					
THE LICE THE LANGE WHICH		_							
will be presented to EB of Bott.			`			T	N.		
the accident) indicated a mechanical lift  Nurses will be responsible to		<b>'</b>					, dd		
be used with two people for all transfers.  update care plan and also to add to C.N.A. assignment		be used with two	people for all transfers.				auu		
sheet. If no issues that									
The record indicated the resident fell could result in accidents are		The record indicate	ated the resident fell	1					
during the transfer on 4/12/12, and observed for 3 months, routine		during the transf	er on 4/12/12, and				e		
sustained a head injury, fractured femur audits will cease thereafter. By		_							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 11FN11

Facility ID: 000423

If continuation sheet Page 4 of 7

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING			(X3) DATE SURVEY COMPLETED 06/14/2012		
1,557.5			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					MAIN ST		
	ON HEALTH AND R	REHAB CENTER			RON, IN 46182		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
1710	and fractured ribs.			1710	what date the systemic change	DATE	
	Physician's orders dated 04/18/12, indicated the use of Hoyer lift for all				will be completed; June 29, 20		
					·		
		s dated 04/21/12,					
		fication order of two					
	assist with mech						
	assist with meen	anical IIIt.					
	During an interv	iew with RN #3 on					
	_	o.m., by telephone, she					
	-	ter the accident QMA #4					
		ne to Resident B's room.					
	She noticed the Hoyer lift was still in the air and the strap that should have been under the resident's right shoulder was not attached to the lift. She indicated CNA #1 and CNA #2 indicated one was putting the resident to bed while the other one						
		side of the bed. She also					
		served the sling was new					
		She indicated QMA #4					
	-	resident on the floor until					
	_	arrived. She indicated she					
	also reminded the CNAs about putting the sling on correctly.						
	On 6/15/12 at 11	:00 a.m., CNA #1 was					
		elephone and indicated					
	<u>-</u>	were both in the room at					
		ccident. She indicated					
		ne hall helping another					
		NA #1 asked her to help					
		ift of Resident #B. She					
	_	1 had already attached the					
		ling to the lift and she					
	1						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 11FN11

Facility ID: 000423

If continuation sheet Page 5 of 7

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING COMPLETED					
155704			B. WIN	IG		06/14/	2012
NAME OF PROVIDER OR SUPPLIER			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MAIN ST		
WALDRON HEALTH AND REHAB CENTER				WALDR	ON, IN 46182		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	watched CNA #2 lift the resident out of						
	her motorized chair with the sling when						
		resident fall out of the					
		ght side onto the floor.					
		e was unable to do					
	I	e she was on the other					
	side of the bed d	ue to lack of space.					
	Δ record review	of an inservice provided					
		ttended by CNA #1 and					
	1 -	the facility on 2/21/12					
	<u> </u>	-					
	indicated the Hoyer Lift must have two people present before using to transfer the resident.						
	resident.						
	During an observ	vation of a Hoyer Lift					
	transfer on 6/14/12 at 4:10 p.m., by other						
		ted that while one CNA					
	· ·	s to mechanically lift the					
		e wheelchair, the other					
		he sling guiding it onto					
	the area of the bed while the CNA at the controls lowered the resident onto the bed safely.						
	Interview with the	ne Administrator on					
	06/14/12 at 3:35	p.m. indicated the					
		ave manufacturer's					
	-	s for the Hoyer lift, but					
		the instructions for					
	1	out of a book by Briggs					
		ed 2006 for long term care					
	_	t was their policy to use					
	-	for the mechanical lift"					
	ule instructions	for the mechanical fift					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 11FN11

Facility ID: 000423

If continuation sheet Page 6 of 7

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155704	A. BUILDING  B. WING	00	COMPLETED 06/14/2012			
	PROVIDER OR SUPPLIER ON HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  505 N MAIN ST  WALDRON, IN 46182					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION			
	out of this book. The instructions were for an Invacare lift which recommended two assist for transfers to and from, but indicated their equipment will permit proper operation with one assist.  This federal tag is related to Complaint IN00108595.  3.1-45(a)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 11FN11

Facility ID: 000423

If continuation sheet

Page 7 of 7